

EXHIBIT G

Last Name: THANE First Name: Brian Middle Initial: E DOB: 06-10-54 Exam Date: 06-13-16**DRIVER HEALTH HISTORY (continued)**

Do you have or have you ever had:	Not				Not		
	Yes	No	Sure		Yes	No	Sure
1. Head/brain injuries or illnesses (e.g., concussion)	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	16. Dizziness, headaches, numbness, tingling, or memory loss	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
2. Seizures, epilepsy	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	17. Unexplained weight loss	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
3. Eye problems (except glasses or contacts)	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	18. Stroke, mini-stroke (TIA), paralysis, or weakness	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
4. Ear and/or hearing problems	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	19. Missing or limited use of arm, hand, finger, leg, foot, toe	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
5. Heart disease, heart attack, bypass, or other heart problems	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	20. Neck or back problems	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
6. Pacemaker, stents, implantable devices, or other heart procedures	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	21. Bone, muscle, joint, or nerve problems	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
7. High blood pressure	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	22. Blood clots or bleeding problems	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
8. High cholesterol	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	23. Cancer	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
9. Chronic (long-term) cough, shortness of breath, or other breathing problems	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	24. Chronic (long-term) infection or other chronic diseases	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
10. Lung disease (e.g., asthma)	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	25. Sleep disorders, pauses in breathing while asleep, daytime sleepiness, loud snoring	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
11. Kidney problems, kidney stones, or pain/problems with urination	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	26. Have you ever had a sleep test (e.g., sleep apnea)?	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
12. Stomach, liver, or digestive problems	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	27. Have you ever spent a night in the hospital?	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
13. Diabetes or blood sugar problems Insulin used	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	28. Have you ever had a broken bone?	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
14. Anxiety, depression, nervousness, other mental health problems	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	29. Have you ever used or do you now use tobacco?	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
15. Fainting or passing out	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	30. Do you currently drink alcohol?	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
				31. Have you used an illegal substance within the past two years?	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
				32. Have you ever failed a drug test or been dependent on an illegal substance?	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>

Other health condition(s) not described above:

☐ Yes ☒ No ☐ Not Sure

Did you answer "yes" to any of questions 1-32? If so, please comment further on those health conditions below.

☐ Yes ☒ No ☐ Not Sure

(Attach additional sheets if necessary)

CMV DRIVER'S SIGNATURE

I certify that the above information is accurate and complete. I understand that inaccurate, false or missing information may invalidate the examination and my Medical Examiner's Certificate, that submission of fraudulent or intentionally false information is a violation of 49 CFR 390.35, and that submission of fraudulent or intentionally false information may subject me to civil or criminal penalties under 49 CFR 390.37 and 49 CFR 386 Appendices A and B.

Driver's Signature: [Signature]Date: 05-13-16**SECTION 2. Examination Report (to be filled out by the medical examiner)****DRIVER HEALTH HISTORY REVIEW**

Review and discuss pertinent driver answers and any available medical records. Comment on the driver's responses to the "health history" questions that may affect the driver's safe operation of a commercial motor vehicle (CMV).

(Attach additional sheets if necessary)